		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023309

Facility Name: Calvin Johnson Care Center

Address: 727 North 17th Street (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: 618-234-3323 **Fax #** 618-234-9477

IDPA ID Number: 37-1024089001

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven C. Wolf

(Title) Executive Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/22/2003

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	186	Skilled (SNF)	132	60,762	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	48	18,219	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	180	78,981	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,518	1,305	3,565	13,388	8
9	SNF/PED					9
10	ICF	36,104	5,177	1,887	43,168	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,622	6,482	5,452	56,556	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.61%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 3,094

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	210,883	20,354	15,853	247,090		247,090		247,090			1
2	Food Purchase		296,551		296,551		296,551		296,551			2
3	Housekeeping	254,932	27,506		282,438		282,438		282,438			3
4	Laundry	78,025	7,368	16,863	102,256		102,256		102,256			4
5	Heat and Other Utilities			223,919	223,919		223,919	2,323	226,242			5
6	Maintenance	62,614	32,930	9,184	104,728		104,728	4,008	108,736			6
7	Other (specify):*											7
8	**TOTAL General Services**	606,454	384,709	265,819	1,256,982		1,256,982	6,331	1,263,313			8
	B. Health Care and Programs											
9	Medical Director			17,124	17,124		17,124		17,124			9
10	Nursing and Medical Records	2,072,741	389,709	118,350	2,580,800	(419,108)	2,161,692		2,161,692			10
10a	Therapy			108,636	108,636	(91,170)	17,466		17,466			10a
11	Activities	48,817	5,720		54,537		54,537		54,537			11
12	Social Services	51,414		3,345	54,759		54,759		54,759			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,172,972	395,429	247,455	2,815,856	(510,278)	2,305,578		2,305,578			16
	C. General Administration											
17	Administrative	164,507		72,460	236,967		236,967	(72,460)	164,507			17
18	Directors Fees											18
19	Professional Services			12,321	12,321		12,321	4,299	16,620			19
20	Dues, Fees, Subscriptions & Promotions			22,141	22,141		22,141	(6,529)	15,612			20
21	Clerical & General Office Expenses	322,853	12,947	52,455	388,255		388,255	10,293	398,548			21
22	Employee Benefits & Payroll Taxes			410,473	410,473		410,473	22,663	433,136			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,439	3,439		3,439	136	3,575			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,569	88,569		88,569	1,108	89,677			26
27	Other (specify):* Contrib/sales tax			6,166	6,166		6,166	(6,166)				27
28	**TOTAL General Administration**	487,360	12,947	668,024	1,168,331		1,168,331	(46,656)	1,121,675			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,266,786	793,085	1,181,298	5,241,169	(510,278)	4,730,891	(40,325)	4,690,566			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Calvin Johnson Care Center #0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			82,998	82,998		82,998	2,986	85,984			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,770	36,770		36,770	(4,865)	31,905			32
33	Real Estate Taxes			29,935	29,935		29,935		29,935			33
34	Rent-Facility & Grounds			345,302	345,302		345,302	10,644	355,946			34
35	Rent-Equipment & Vehicles			4,826	4,826		4,826	3,071	7,897			35
36	Other (specify):*											36
37	**TOTAL Ownership**			499,831	499,831		499,831	11,836	511,667			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					510,278	510,278		510,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			14,564	14,564		14,564		14,564			41
42	Provider Participation Fee			118,471	118,471		118,471		118,471			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			133,035	133,035	510,278	643,313		643,313			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,266,786	793,085	1,814,164	5,874,035		5,874,035	(28,489)	5,845,546			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,865)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,441)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,725)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,138)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,169)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(4,373)	sch VII	34
35	Other- Attach Schedule	(5,947)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,320)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,489)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	T Shirt Sales	$ (5,328)	22	1
2	Out of State Travel	(619)	24	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,947)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,323	0	0	0	0	0	0	0	0	2,323	5
6	Maintenance	0	0	4,008	0	0	0	0	0	0	0	0	4,008	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	6,331	0	0	0	0	0	0	0	0	6,331	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(72,460)	0	0	0	0	0	0	0	0	(72,460)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,299	0	0	0	0	0	0	0	0	4,299	19
20	Fees, Subscriptions & Promotions	(7,138)	0	609	0	0	0	0	0	0	0	0	(6,529)	20
21	Clerical & General Office Expenses	0	0	10,293	0	0	0	0	0	0	0	0	10,293	21
22	Employee Benefits & Payroll Taxes	(5,328)	0	27,991	0	0	0	0	0	0	0	0	22,663	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(619)	0	755	0	0	0	0	0	0	0	0	136	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,108	0	0	0	0	0	0	0	0	1,108	26
27	Other (specify):*	(6,166)	0	0	0	0	0	0	0	0	0	0	(6,166)	27
28	**TOTAL General Administration**	(19,251)	0	(27,405)	0	0	0	0	0	0	0	0	(46,656)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,251)	0	(21,074)	0	0	0	0	0	0	0	0	(40,325)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	2,986	0	0	0	0	0	0	0	0	2,986	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,865)	0	0	0	0	0	0	0	0	0	0	(4,865)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	10,644	0	0	0	0	0	0	0	0	10,644	34
35	Rent-Equipment & Vehicles	0	0	3,071	0	0	0	0	0	0	0	0	3,071	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,865)	0	16,701	0	0	0	0	0	0	0	0	11,836	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,116)	0	(4,373)	0	0	0	0	0	0	0	0	(28,489)	45

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Eldercare of Alton	Alton	Eldercare Inc	Belleville	Nur Home Mgt
Steve Wolf	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Adm Wages	$ 83,303	Eldercare Inc		$ 83,303	$	1
2	V	21-1	Home Office Wages	143,707	Eldercare Inc		143,707		2
3	V	17-3	Home Office Adm expenses	72,460	Eldercare Inc		68,087	(4,373)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 299,470			$ 295,097	$ * (4,373)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Eldercare Inc	0.00%	$ 2,323	$ 2,323	15
16	V	6	Maintenance		Eldercare Inc	0.00%	4,008	4,008	16
17	V	17	Administrative Wages	83,303	Eldercare Inc	0.00%	83,303		17
18	V	19	Professional Services		Eldercare Inc	0.00%	4,299	4,299	18
19	V	20	Fees,Subscriptions		Eldercare Inc	0.00%	609	609	19
20	V	21	Clerical&General Wages	143,707	Eldercare Inc	0.00%	143,707		20
21	V	21	Clerical&General		Eldercare Inc	0.00%	10,293	10,293	21
22	V	22	Employee Benefits		Eldercare Inc	0.00%	27,991	27,991	22
23	V	24	Travel&Seminars		Eldercare Inc	0.00%	755	755	23
24	V	26	Ins. Prop		Eldercare Inc	0.00%	1,108	1,108	24
25	V	30	Depreciation		Eldercare Inc	0.00%	2,986	2,986	25
26	V	34	Rent Facility		Eldercare Inc	0.00%	10,644	10,644	26
27	V	35	Rent Equipment		Eldercare Inc	0.00%	3,071	3,071	27
28	V	17	Home Office Allocation	72,460	Eldercare Inc	0.00%		(72,460)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 299,470			$ 295,097	$ * (4,373)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Wolf	President	Exec. Admin.	30.00	A	20	40.00	Salary	$ 83,303	17-1	1
2											2
3											3
4											4
5											5
6			A Columbia Conv Center		118,474						6
7			Eldercare of Alton		86,161						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 83,303		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare Inc
Street Address: 2810 Frank Scott Pkway West Ste 820
City / State / Zip Code: Belleville, IL 62223
Phone Number: (618-234-2273
Fax Number: (618-234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Census	115,052	2	$ 4,726	$	56,556	$ 2,323	1
2	6	Maintenance	Census	115,052	2	8,154		56,556	4,008	2
3	17	Administrative	Census	115,052	2	169,464	169,464	56,556	83,303	3
4	19	Professional Services	Census	115,052	2	8,745		56,556	4,299	4
5	20	Fees,Subscriptions	Census	115,052	2	1,238		56,556	609	5
6	21	Clerical&General	Census	115,052	2	292,343	292,343	56,556	143,707	6
7	21	Clerical&General	Census	115,052	2	20,940		56,556	10,293	7
8	22	Employee Benefits	Census	115,052	2	56,940		56,556	27,991	8
9	24	Travel&Seminars	Census	115,052	2	1,536		56,556	755	9
10	26	Ins. Prop	Census	115,052	2	2,254		56,556	1,108	10
11	30	Depreciation	Census	115,052	2	6,075		56,556	2,986	11
12	34	Rent Facility	Census	115,052	2	21,654		56,556	10,644	12
13	35	Rent Equipment	Census	115,052	2	6,248		56,556	3,071	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 600,317	$ 461,807		$ 295,097	25

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Union Planters		X	Open Line Of Credit	Demand	2/5/02	2,000,000	936,000	2/5/04	Prime	36,770	6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 936,000			$ 36,770	9
	B. Non-Facility Related*											
10								Int Income			(4,865)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,865)	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 936,000			$ 31,905	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	47,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	38,527	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,173)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,108	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	29,935	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	41,124	8
	1999	43,632	9
	2000	43,026	10
	2001	47,005	11
	2002	38,527	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calvin Johnson Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0023309

CONTACT PERSON REGARDING THIS REPORT David Read

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-211-030	Nursing Home 4.18 Acres	$ 38,526.68	$ 38,526.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,526.68	$ 38,526.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,326 B. General Construction Type: Exterior Brick Frame concrete/steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bldg Imp			1982	600		10			600	9
10	1983 Audit			1983	4,085		10			4,085	10
11	Bldg Imp			1983	49,553		10			49,553	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160	359	20	359		6,981	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17	Canopies			1985	6,333		10			6,333	17
18	Sidewalks			1985	7,800		15			7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remodeling			1990	53,033	2,607	10-15y	2,607		49,122	23
24	Remodeling			1991	51,920	2,912	5-10y	2,912		43,448	24
25	Remodeling			1992	140,195	6,912	5-15y	6,912		116,001	25
26	Remodeling			1993	52,694	4,876	5-15y	4,876		30,750	26
27	Hall Monitor System			1994	3,208	204	15-20y	204		1,984	27
28	Improvements			1995	27,040	1,853	5-15y	1,853		23,313	28
29	Elevator			1996	4,929	329	15	329		2,465	29
30	Awnings			1996	4,195	420	10	420		3,041	30
31	Rooftop			1996	10,643	1,330	8	1,330		9,978	31
32	Renovations Paint/Wallpaper			1996	1,000		5			1,000	32
33	A/C Work & Carpeting			1997	7,032	269	5-15y	269		4,883	33
34	Fence			1998	1,250	156	8	156		939	34
35	Interior Renovation			1998	11,308	1,089	5-15y	1,089		6,189	35
36	Interior Renovation			1999	53,624	5,746	5-15y	5,746		26,071	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Cubicle Tracks	2000	$ 14,481	$ 965	15	$ 965	$	$ 3,379	37
38	Renovations Interior	2000	12,015	1,202	10	1,202		4,205	38
39	Renovations Interior	2000	7,124	1,425	5	1,425		4,987	39
40	Landscaping	2000	21,213	2,121	10	2,121		6,894	40
41	Renovations Interior	2001	15,525	1,552	10	1,552		3,881	41
42	Renovations Interior	2001	45,895	3,060	15	3,060		8,414	42
43	Kitchen hood- stainless steel	2002	21,235	1,416	15	1,416		1,770	43
44	Fire alarm control panel	2002	5,857	164	10	164		245	44
45	insurance proceeds for control panel	2003	(4,221)						45
46	Fire Alarm panel	2003	1,120	112	10	112		112	46
47	Bldg generator	2003	19,164	958	20	958		958	47
48	HVAC units	2003	6,158	616	10	616		616	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 708,278	$ 42,653		$ 42,653	$	$ 475,107	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 398,438	$ 39,057	$ 39,057	$	5-20 yr	$ 241,458	71
72	Current Year Purchases	19,631	1,288	1,288		5-15 yr	1,288	72
73	Fully Depreciated Assets	179,288					179,288	73
74	retirements	(12,345)					(12,345)	74
75	TOTALS	$ 585,012	$ 40,345	$ 40,345	$		$ 409,689	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1971 Bus	1977	$ 4,339	$	$	$		$ 4,339	76
77	Facility Use	1989 Sta Wagon	1992	8,550					8,550	77
78	Lift for Bus	Lift for Bus	1995	4,299					4,299	78
79										79
80	TOTALS			$ 17,188	$	$	$		$ 17,188	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,310,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,998	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 901,984	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes Inc

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969	180	4/1/77	$ 345,302	20	5	3
4	Additions							4
5	Home Office				10,644	5		5
6								6
7	TOTAL		180		$ 355,946 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 08/01/2002
Ending 08/01/2007

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 7,897 Description: dietary-4550/office 276/home office3071
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-6	hrs	$	446	$ 27,464	$	446	$ 27,464	1
2	Licensed Speech and Language Development Therapist	39-6	hrs		128	10,154		128	10,154	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-6	hrs		886	53,552		886	53,552	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				102,503		102,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-6	15710	249,991	monthly	6,000	60,614	15,710	316,605	12
13	Other (specify):									13
14	TOTAL			$ 249,991	1,460	$ 97,170	$ 163,117	17,170	$ 510,278	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 108,054	$	1
2	Cash-Patient Deposits	46,285		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,012,067		3
4	Supply Inventory (priced at cost)	44,335		4
5	Short-Term Investments			5
6	Prepaid Insurance	77,041		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,287,782	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	27,295		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	704,192		15
16	Equipment, at Historical Cost	602,200		16
17	Accumulated Depreciation (book methods)	(897,899)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 435,788	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,723,570	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 383,228	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,285		28
29	Short-Term Notes Payable	936,000		29
30	Accrued Salaries Payable	38,578		30
31	Accrued Taxes Payable (excluding real estate taxes)	680		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,108		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,443,879	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	711,340		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 711,340	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,155,219	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 568,351	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,723,570	$	48

***(See instructions.)**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 327,697	1
2	Restatements (describe):		2
3	**Prior period adjustment to book depreciation**	211	3
4	**Prior period adjustment insurance proceeds fire panel**	(4,223)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 323,685	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	244,666	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 244,666	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 568,351	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,577,332	1
2	Discounts and Allowances for all Levels	(293,642)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,283,690	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,695	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,695	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	19,948	12
13	Barber and Beauty Care	170	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	189,630	17
18	Sale of Supplies to Non-Patients	375,672	18
19	Laboratory	23,541	19
20	Radiology and X-Ray	1,554	20
21	Other Medical Services	77,346	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 687,861	23
	D. Non-Operating Revenue		
24	Contributions	74	24
25	Interest and Other Investment Income***	13,490	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,564	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Federal Income Taxes	17,893	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,893	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,118,703	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,256,982	31
32	Health Care	2,815,856	32
33	General Administration	1,168,331	33
	B. Capital Expense		
34	Ownership	499,831	34
	C. Ancillary Expense		
35	Special Cost Centers	14,564	35
36	Provider Participation Fee	118,471	36
	D. Other Expenses (specify):		
37			37
38	Rounding	2	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,874,037	40
41	**Income before Income Taxes (line 30 minus line 40)****	244,666	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 244,666	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation.** return on extension

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,425	1,425	$ 33,712	$ 23.66	1
2	Assistant Director of Nursing	1,769	1,769	40,088	22.66	2
3	Registered Nurses	8,885	9,240	224,152	24.26	3
4	Licensed Practical Nurses	25,629	26,654	517,618	19.42	4
5	Nurse Aides & Orderlies	96,700	100,568	1,010,709	10.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,870	1,950	18,996	9.74	8
9	Activity Director					9
10	Activity Assistants	5,919	6,156	48,817	7.93	10
11	Social Service Workers	4,258	4,428	51,414	11.61	11
12	Dietician	2,000	2,080	28,191	13.55	12
13	Food Service Supervisor					13
14	Head Cook	2,000	2,080	25,074	12.05	14
15	Cook Helpers/Assistants	20,762	21,592	157,618	7.30	15
16	Dishwashers					16
17	Maintenance Workers	5,772	6,003	62,614	10.43	17
18	Housekeepers	31,960	33,238	254,932	7.67	18
19	Laundry	9,533	9,914	78,025	7.87	19
20	Administrator	2,000	2,080	81,204	39.04	20
21	Assistant Administrator	2,000	2,080	41,770	20.08	21
22	Other Administrative	1,040	1,040	83,303	80.10	22
23	Office Manager					23
24	Clerical	18,550	19,292	281,083	14.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Inserv/QA	4,044	4,206	66,874	15.90	32
33	Other(specify) Respiratory	8,174	8,501	160,592	18.89	33
34	TOTAL (lines 1 - 33)	254,290	264,296	$ 3,266,786 *	$ 12.36	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	468	$ 12,309	1-3	35
36	Medical Director	monthly	17,124	10-3	36
37	Medical Records Consultant	17	595	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	98	3,325	12-3	45
46	Other(specify)				46
47	Vent Unit Med Dir	monthly	6,000	39-6	47
48					48
49	TOTAL (lines 35 - 48)	583	$ 39,353		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	790	23,541	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	790	$ 23,541		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Ford	Administrator	0	$ 81,204
Steven Wolf	Owner/Exec Admin	30	83,303
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 164,507

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 72,460
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 72,460

C. Professional Services

Vendor/Payee	Type	Amount
Flynn & Guymon	Legal	$ 604
Greensfelder, Hemker	Legal	897
Wesells & Pautsch	Legal	120
P. Michael Read	Legal	1,606
Van Ostrand & Elvidge	Legal	9,094
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 12,321

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,995
Unemployment Compensation Insurance	41,144
FICA Taxes	228,112
Employee Health Insurance	41,811
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office payroll taxes	16,696
Home Office insurance	11,295
Other employee benefits	15,411
TOTAL (agree to Schedule V, line 22, col.8)	$ 438,464

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
	N/A	$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	11,645
Health Care Worker Background Check	1,994
(Indicate # of checks performed 124)	
Illinois Secretary of State	78
HIPAA website and materials	306
Advertising and PR	6,711
Various subscriptions	780
Home office allocation	609
Less: Public Relations Expense	( )
Non-allowable advertising	(6,711)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,820
Home Office travel and seminar	755
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,575

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-20 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,011** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **118,471**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.